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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G190	A. BUILDING _____ B. WING _____	03/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	1608 EVARTS ST, NE WASHINGTON, DC 20018

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W 000	INITIAL COMMENTS A recertification survey was conducted from March 18, 2009, through March 20, 2009. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a client population of four males with various disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with staff, and the review of administrative records, including the facility's incident management system.	W 000	Received GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E. 2ND FLOOR WASHINGTON, D.C. 20002	
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all entries in clients' records were signed and dated, for one of the two clients in the sample. (Client #2) The findings include: The facility failed to ensure that the Client #2's Behavior Support Plan (BSP) was signed and dated. On March 20, 2009, at approximately 1:15 PM, interview with the Incident Management Coordinator (IMC) and the Qualified Mental Retardation Professional (QMRP) and the review of Client #2's Behavior Support Plan (BSP) revealed that the report had not been dated. Further interview with the IMC revealed that the client's Individual Support Plan (ISP) occurred on	W 114	Client #2 BSP will be dated and signed by both Behavior Specialist and supervising psychologist. In the future, the QMRP will ensure all assessments are dated and signed upon reciept.	5/1/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Constance A. Reese	Program Director	4/24/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 114	Continued From page 1 May 2, 2008, however, the date the BSP was developed could not be determined. Further review of the BSP additionally revealed that the supervising psychologist failed to sign the BSP after its development .	W 114		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for the one of the two clients included in the sample. (Clients #1) The finding includes: The facility failed to ensure that informed consent was obtained from Client #1 and/or his legal guardian prior to the administration of his psychotropic medications. Observation of the medication administration on March 18, 2009 at approximately 8:45 AM, revealed Client #1 received Carbamazepine 200 mg, Fluoxetine HCL 10 mg and Zyprexa 5 mg. Interview with the medication nurse revealed that	W 124	In the future, QMRP/ Manager will ensure consent to treatment is signed annually by guardian. 4/22/09	

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W 124	Continued From page 2 the client received these medication to address his maladaptive behaviors(i.e. food snatching, spitting and aggression). Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on March 19, 2009, at approximately 11:40 AM confirmed Client #1 was prescribed the aforementioned psychotropic medications. Further discussion with the QMRP revealed that the client did not have the capacity to give informed consent for the use of psychotropic medications, medical treatments and habilitation services. According to the QMRP, Client #1's mother was the responsible person for signing consent for treatment, care and medical procedures. Further review of Client #1's habilitation and medical records on March 20, 2009, at 11:30 AM revealed a psychological assessment dated May 2, 2009, that verified the QMRP's statements and documented that Client #1 "is not competent to render decisions regarding his habilitation. Nor is he able to contribute to decisions regarding his placement due to deficits in both cognitive and adaptive areas." Review of the client's medical record and additional interview with the QMRP on March 20, 2009, at 2:00 PM failed to provide evidence that Client #1's treatment needs, including the benefits and potential side effects associated with his psychotropic medications, and the right to refuse treatment, had been explained to him and an authorized representative.	W 124		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be	W 159		

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W 159	Continued From page 3 integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives. (See W252) 2. The QMRP failed to ensure that a comprehensive functional assessment had been conducted that identified each client's specific developmental and behavioral management needs. (See W214) 3. The QMRP failed to coordinate services to ensure Client #2's day program was provided with current physician's orders. On March 18, 2009, at approximately 11:30 AM, interview with Client #2's day program case manager revealed that the client received a noon dosage of medication at the day program. Further interview with the case manager revealed that the current physician's order on file was for the month of February 2009. Interview with the day program nurse confirmed that Client #2's received Depakote 250 mg at noon. According to further interview with the day program nurse, the physician orders were forwarded to the day program monthly however, the group home had	W 159	1. QMRP/ Manager will plan a community activity for Client #1 once a month to a local restaurant and monitor for implementation. Staff will receive additional training on documentation. 4/25/09 2. The treating psychiatrist will provide an annual psychiatric assessment and/ or as stated in the psychiatric recommendation. 5/15/09 3. The primary care nurse will review physician's orders monthly for Client #2 and deliver to day program at the beginning of each month. 5/1/09	

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W 159	Continued From page 4 not forwarded the client's March 2009 orders. Interview with the facility's nurse on March 19, 2009, at approximately 11:00 AM verified that the client's orders were delivered to the day program on a monthly basis. At the time of the survey, the QMRP failed to coordinate services to ensure Client #2's day program received monthly physician orders timely.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record verification, the facility failed to provide each employee with initial and continuing training that enabled the employee to perform his or her duties effectively and competently for one of the two clients in the sample. (Clients #1) The finding include: The facility failed to ensure staff was trained to effectively document Client #1's progress with his community outing objective. (See W252)	W 189	Cross reference W159 (1)	4/24/09
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record	W 214		

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W 214	Continued From page 5 review, the facility failed to ensure a comprehensive functional assessment that identified the clients specific developmental and behavioral management needs was conducted for two of two clients included in the sample. (Client #1 and 2) The findings include: 1. Observation of the medication administration on March 18, 2009, at approximately 8:45 AM, revealed Client #1 received Carbamazepine 200 mg, Fluoxetine HCL 10 mg and Zyprexa 5 mg. Interview with the medication nurse revealed that the client received these medication to address his maladaptive behaviors(i.e. food snatching, spitting and aggression). Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on March 19, 2009, at approximately 11:40 AM, that confirmed Client #1 was prescribed the aforementioned psychotropic medications. Review of Client #3's habilitation and medical records revealed he had diagnoses that included Explosive Disorder and Obsessive Compulsive Behavior. Further review of the records failed to evidence that a comprehensive psychiatric assessments had been conducted that verified the client's aforementioned diagnoses and the use of his medications. Additionally, review of the March 2009 physician's order and the February psychotropic medication review minutes revealed that the client's psychotropic medication regimen had been adjusted. At the time of the survey, the QMRP was unable to provide evidence of a current psychiatric assessment. 2. Observation of the medication administration	W 214	1. Cross reference W159 (2) 2. Cross reference W159 (2)	5/15/09 5/15/09

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W 214	Continued From page 6 on March 18, 2009 at approximately 9:15 AM revealed Client #2 received Clonazepam 0.5 mg, Divalproex Sodium 750 mg, Fluvoxamine Maleate 100 mg and Nuerontin 600 mg. Interview with the medication nurse revealed that the client received these medications to address his maladaptive behaviors (i.e. tantruming, aggression, property damage and non-compliance). Interview was conducted with the QMRP on March 19, 2009, at approximately 11:40 AM, that confirmed Client #2 was prescribed the aforementioned psychotropic medications. Further interview was conducted to ascertain if the client had a current psychiatric assessment. Review of Client #2's habilitation and medical records revealed the client had diagnoses that included Intermittent Explosive Disorder and Behavior Issues. Further review of the records failed to evidence a comprehensive psychiatric assessments which verified the client's psychiatric diagnosis. At the time of the survey, the QMRP was unable to provide evidence of a current psychiatric assessment was available.	W 214		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives for one of the two client's in the sample. (Clients #1)	W 252	Cross reference W159 (1)	4/25/09

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W 252	Continued From page 7 The finding includes: The facility failed to ensure that direct care staff documented on Client #1's program objective monthly. On March 20, 2009, at approximately 2:00 PM, interview with the QMRP and review of Client #1's Individual Program Plan (IPP) revealed a program objective for Client #1 to participate in a community outing at a local restaurant. The objective stated, " [The client] will be able to eat in a restaurant without grabbing food once a month given verbal assistance." Review of the program data failed to evidence that data had been collected for the months of December 2008, January 2009 and February 2009. According to the QMRP, this objective should be implemented monthly and the frequency for data collection was monthly as well. At the time of the survey, there was no documented evidence that this objective was being implemented.	W 252		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC) for two of the two clients in the sample. (Client #1 and #2)	W 262		

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W 262	Continued From page 8 The findings include: The facilities Human Rights Committee (HRC) failed to have documented evidence of approved use of psychotropic medications and behavior support plans for Client #1 and #2 as evidence below: 1. Observation of the medication administration on March 18, 2009, at approximately 8:45 AM revealed, Client #1 received Carbamazepine 200 mg, Fluoxetine HCL 10 mg and Zyprexa 5 mg. Interview with the medication nurse revealed that the client received these medications to address his maladaptive behaviors(i.e. food snatching, spitting and aggression). Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on March 19, 2009, at approximately 11:40 AM, revealed that the QMRP confirmed that the client was prescribed the aforementioned psychotropic medications. Further interview was conducted to ascertain if the HRC had reviewed and approved the restrictive measures prior to there implementation. According to the QMRP, a Human Rights Committee (HRC) committee meeting was held on November 11, 2008, to discuss all clients' rights, behavior support plans and psychotropic medications. Review of the HRC minutes, however, did not evidence that the committee discussed Client #1's psychotropic medication regimen and/or her BSP specifically. Interview with the facility's QMRP/Incident Management Coordinator revealed that	W 262	In the future, QMRP will ensure that HRC will approve use of psychotropic medications and BSP's for Client #1, and #2, as well as all other individuals. HRC will submit documentation of approval/ refusal.	5/4/09

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W 262	Continued From page 9 documents had been signed by the committee and approved. At the time of the survey, there was no documented evidence that the HRC had reviewed and approved Client #1's behavior support plan and psychotropic medication prior to the facility's usage. 2. Observation of the medication administration on March 18, 2009, at approximately 9:15 AM, revealed Client #2 received Clonazepam 0.5 mg, Divalproex Sodium 750 mg, Fluvoxamine Maleate 100 mg and Nuerontin 600 mg. Interview with the medication nurse revealed that the client received these medications to address his maladaptive behaviors (i.e. tantruming, aggression, property damage and non-compliance). Interview was conducted with the QMRP on March 19, 2009, at approximately 11:40 AM, that confirmed Client #1 was prescribed the aforementioned psychotropic medications. Further interview was conducted to ascertain if the restrictive measures had been reviewed and approved prior to their implementation. According to the QMRP, a Human Rights Committee (HRC) committee meeting was held on November 11, 2008 to discuss all clients' rights, behavior support plan and psychotropic medication regimens. Review of the HRC minutes, however, did not provide evidence that the committee discussed Client #2's psychotropic medication regimen and/or his BSP. At the time of the survey, there was no documented evidence that the HRC had reviewed and approved Client #2's behavior support plan and psychotropic medication prior to the facility's usage.	W 262		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing	W 331		

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W 331	Continued From page 10 services in accordance with their needs. This STANDARD is not met as evidenced by: Based observation, interview and record review the facility failed to ensure nursing services in accordance with the clients needs for one of three clients included in the sample. (Client #2) The finding includes: 1. The facility's nursing staff the facility failed to ensure that mecications were administered in accordance with physician's orders. (See W368) 2. The nursing staff failed to implement an effective system of ensure day program administration of noon time medications as evidenced below: Interview with the Registered Nurse on March 19, 2009 at 9:27 AM, revealed the Client #2 day program was to forward monthly Medication Administration Records (MAR) from the group home. The ongoing purpose was to ensure that day programs was provided current medical information and accurate prescribed medications especially Client #2 who received a noon dosage of Depakote 250 mg. Further interview with the nurse revealed that the client is prescribed this medication for his diagnosis of seizures. Review of the day program MAR's for November 13 and 14, 2008 revealed that on the client was absent from the day program due to a vacation in Baltimore. Further review of the MAR's during the interview and the review of nursing notes a later the same day failed to provided documented evidence that client was administered his noon	W 331	The [redacted] nurse will review the MAR on a weekly basis to ensure proper documentation of medication administration. The QMRP and the Residential Manager will notify the nursing staff when Client #2 is not at his day program.	4/30/09

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W 331	Continued From page 11 seizure medicat on while on vacation. Review of the day programs MAR for February 2009 revealed on the 19th the client was absent from the day program. According to the staff and the QMRP he was at a schedules medical appointment. Further review of the group home MAR did not evidence that the client was administered his noon seizure medication for either of the aforementioned days he was absent form his day program. At the time of the survey, there was no documented evidence that the nursing staff had an effective system to ensure Client #2 was administered his noon dosage of medication as prescribed when not attending his day program.	W 331		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on interview and record reviews, the facility failed to establish and maintain a systems that ensures that an individuals medication records were maintained for two of the four client's residing in the facility. (Client #1 and #3) The findings include: The facility failed to ensure an effective system for documenting Client #1's presribed medications as evidence by the following: 1. The facility failed to ensure documentated evidence in the MAR as to why Client #1's Divalproex Sodium DR 250 mg was not administered as prescribed. (See W368)	W 365		

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W 365	Continued From page 12 2. The facility failed to ensure that Client #1's prescribed Bactrim DS treatment was documented in the MAR. (See W368) 3. The facility failed to ensure Client #1's Debrox treatment was documented in the MAR . (See W368)	W 365	Cross reference W331	4/30/09
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were administered in accordance with physician's orders for one of the two clients in the sample. (Client's #1 and #2) The findings inc ude: The facility failed to ensure that each client received prescribed medication as order by the physician as follows: 1. On March 19, 2009, at approximately 9:25 AM, interview with the medication nurse and review of the Medication Administration Records (MAR) revealed that the medication nurse documented on March 14, 2009 that Client #2's Divalproex Sodium DR 250 mg was not administered due to the client not being in the group home at the time of the medication administration. Further interview with nurse revealed that he/she was unaware as to if the primary care physician had been notified that the client missed his noon dosage of medication.	W 368		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G190	A. BUILDING _____ B. WING _____	03/20/2009

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W 368	Continued From page 13	W 368	Cross reference W331	4/30/09

Note: Review of the medical record on the same day revealed the client had a diagnosis of seizure. Review of the Physician orders revealed that the aforementioned medication was prescribed for the client's seizure disorder.

2. On March 19, 2009, at 9:33 AM, interview with the RN and review of the medication records for Client #1 revealed he was prescribed Bactrim DS P.O. BID for 7 days. Further interview revealed that the medication was prescribed for an infection.

Review of the physician's order reflected that the order originated on March 13, 2009 and the medication started on March 14, 2009. Review of the MAR did not evidence that the Bactrim medication was administered for March 16, 2009, in the morning or the evening as prescribed. Review of the nurses' notes and the March 2009 MAR failed to provide documented evidence as to why this medication was not administered and/or evidence that the medication was administered for seven days as prescribed.

3. On March 19, 2009, at approximately 9:40 AM, interview with the Registered Nurse and the review of the medication records failed to ensure that Client #1's Debrox treatment for each ear was administered on March 2, 2009 in the morning. The order further included " 3 drops to each ear every other month the first through the 3rd (Jan, Feb, May, July, Sept, Nov)". Further interview with the nurse failed to evidence the purpose this treatment was not administered as prescribed.

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R 000	INITIAL COMMENTS A licensure survey was conducted from March 18, 2009 through March 20, 2009. The survey was initiated using the fundamental survey process. A random sample of two residents was selected from a resident population of four males with various disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with staff, and the review of administrative records, including the facility's incident management system.	R 000		

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Constance A. Reese — Program Director — 4/24/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATE FORM 6899 UPIH11 If continuation sheet 1 of 1

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I 000	INITIAL COMMENTS A licensure survey was conducted from March 18, 2009 through March 20, 2009. The survey was initiated using the fundamental survey process. A random sample of two residents was selected from a resident population of four males with various disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with staff, and the review of administrative records, including the facility's incident management system.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure windows were equipped with curtains, shades or blinds, that were clean and in good repair. The finding includes: An environmenta walk-through was conducted on March 20, 2009, at approximately 3:00 PM, that revealed the blinds in the living room front window and side window were torn. Additionally, the blinds in the basement window were ripped.	I 022	Living room, basement, and side window blinds will be supplied with curtains, shades, or blinds which are kept clean and in good repair.	5/1/09
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of	I 090		

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I 090	Continued From page 1 accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior of the facility in a safe, clean, orderly, and attractive manner. The findings include: On March 20, 2009, beginning at 3:15 PM, observation of the environment revealed the following concerns: Internal	I 090		
	1. An electrical outlet located in the second level television room had wires that were exposed.		1. The electrical outlet on second level in the television room will be repaired to cover exposed wires.	3/20/09
✓	2. The wood paneling in the television room had a large hole.		2. The large hole in wood panel-ing will be repaired.	5/8/09
✓	3. The radiator covers in Residents #2, #3, and #4's bedrooms were obseved to have sharp edges.		3. Radiator covers in Client #2, #3, and #1 bedrooms will be re-paired.	5/8/09
✓	4. The upstairs bathroom's towel rack was missing the towel bar.		4. Towel rack will be replaced	5/8/09
✓	5. The bathroom ceiling on the second level had a large crack in the bulking wall.		5. Bathroom ceiling on the second level will be repaired.	5/8/09
✓	6. The second floor bathroom shower area was missing a soap dish. A large hole was in the tile where the soap dish may have been.		6. Soap dish will be replaced	5/8/09
✓	7. The radiator cover in living room exposed had very sharp edges.			

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I 090	Continued From page 2 8. The heating system in the basement was leaking water into a bucket that had overflowed. 9. The wall next to the heating system at the base was observed to have water damage and corrosion. 10. The toilet seat in the upstairs bathroom was discolored. External The dryer vent leading from the facility expelled lint. Lint was observed in the yard, on the side walk and on the exterior of the house.	I 090	7. Radiator cover in living room will be repaired. 8. The heating system in the basement will be inspected for leakage and repaired. 9. The wall next to heating system will be repaired for water damage. 10. The toilet seat in upstairs bathroom will be replaced.	5/8/09 5/8/99 5/8/09 5/8/09
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based interview and record review, the GHMRP failed to have current job descriptions for all employees. The finding includes: Interview and review of the personnel files conducted on March 20, 2009, at approximately 3:30 PM revealed that GHMRP failed to provide evidence of current signed job descriptions for three direct care staff and the Qualified Mental Retardation Professional.	I 203	Dryer vent leading from the facility will be inspected and serviced. QMRP/ Manager will have all employees review and sign job description annually.	5/8/09 4/24/09
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and	I 206		

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I 206	Continued From page 3 annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding incluces: Interview with the QMRP on March 20, 2009, and review of the GHMRP's personnel records at 2:15 PM revealed that the GHMRP failed to provide evidence that current health certificates were on file for two direct care staff and thirteen consultants.	I 206	QMRP/ Manager will request health certificates from identified direct care staff and consultants.	5/8/09
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the	I 401		

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I 401	Continued From page 4 GHMRP failed to provide diagnosis, evaluation, treatment services and necessary follow up services to prevent deterioration or further loss of functioning for five of the five resident in the GHMRP. (Residents #1, #2, #3, #4) The findings include: 1. Observation of the medication administration on March 18, 2009 at approximately 8:45 AM, revealed Resident #1 receiving Carbamazepine 200 mg, Fluoxetine HCL 10 mg and Zyprexa 5 mg. Interview with the medication nurse revealed that the resident received these medication to address his maladaptive behaviors(i.e. food snatching, spitting and aggression). Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on March 19, 2009 at approximately 11:40 AM, that revealed Resident #1 confirmed that the resident was prescribed these aforementioned psychotropic medications. Further interview was conducted to ascertain if the resident had a current psychiatric assessment. The QMRP further added that the Resident #1 is prescribed psychotropic medications and had a behavior management plan which address his maladaptive behaviors. Review of Resident #3's habilitation and medical records revealed his diagnoses: Explosive Disorder and Obsessive Compulsive Behavior. Further review of the records failed to evidence a psychiatric assessments had been conducted in order to verified the resident diagnosis and the use of his medications. Additionally, review of the March 2009 physician's order and the February psychotropic medication review minutes revealed that the resident's psychotropic medication	I 401		

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I 401	Continued From page 5 regimen had been adjusted. At the time of the survey, the QMRP was unable to provide evidence of a current psychiatric assessment. 2. Observation of the medication administration on March 18, 2009 at approximately 9:15 AM revealed Resident #2 receiving Clonazepam 0.5 mg, Divalproex Sodium 750 mg, Fluvoxamine Maleate 100 mg and Nuerontin 600 mg. Interview with the medication nurse revealed that the resident received these medications to address his maladaptive behaviors (i.e. tantruming, aggression, property damage and non-compliance). Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on March 19, 2009 at approximately 11:40 AM, confirmed that Resident #1 was prescribed these aforementioned psychotropic medications. Further interview was conducted to ascertain if the resident had a current psychiatric assessment. The QMRP further added that the Resident #2 use psychotropic medications and has a behavior management plan which address his maladaptive behaviors. Review of Resident #2's habilitation and medical records revealed the resident's diagnoses: Intermittent Explosive Disorder and Behavior Issues. Further review of the records failed to evidence a psychiatric assessments which verified the resident psychiatric diagnosis. Additionally, review of the March 2009 physician's order and the review of the psychotropic medication minuted reflected the current psychotropic medication regimen as described. At the time of the survey, the QMRP was unable to provide evidence of a current psychiatric assessment was available.	I 401	**The treating psychiatrist will provide a psychiatric assessment annually and/ or as stated in the psychiatric recommendations.**	5/15/09

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I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP's nursing staff failed to ensure medication administration records were reviewed and maintained for two of the two esidents in the sample. (Resident #1 and #2) The finding includes: On March 18, 2009 at approximately 8:00 AM, review of the Medication Administration Records (MAR) revealed that the nursing staff failed to ensure its system of documentation was maintained as follows: 1. On March 19, 2009, at approximately 9:25 AM, Interview with the medication nurse and review of the Medication Administration Records (MAR) revealed that the medication nurse documented on March 14, 2009 that Resident #2's Divalproex Sodium DR 250 mg was not administered due to the Resident not being in the group home at the time of the medication administration. Further interview with nurse revealed that he/she was unaware as to if the primary care physician had been notified that the Resident missed his noon dosage of medication. Note: Review of the medical record on the same day revealed the Resident had a diagnosis of seizure. Review of the Physician orders revealed that the aforementioned medication was prescribed for the client's seizure disorder. 2. On March 19, 2009, at 9:33 AM, interview	I 474	Cross reference W331	4/30/09

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I 474	Continued From page 7 with the RN and review of the medication records for Resident #1 revealed he was prescribed Bactrim DS P.O. BID for 7 days. Further interview revealed that the medication was prescribed for an infection. Review of the physician's order reflected that the order originated on March 13, 2009 and the medication started on March 14, 2009. Review of the MAR did not evidence that the Bactrim medication was administered for March 16, 2009, in the morning or the evening as prescribed. Review of the nurses' notes and the March 2009 MAR failed to provide documented evidence as to why this medication was not administered and/or evidence that the medication was administered for seven days as prescribed. 3. On March 19, 2009, at approximately 9:40 AM, Interview with the Registered Nurse and the review of the medication records failed to ensure that Resident #1's Debrox treatment for each ear was administered on March 2, 2009 in the morning. The order further included " 3 drops to each ear every other month the first through the 3rd (Jan, Feb, May, July, Sept, Nov)". Further interview with the nurse failed to evidence the purpose this treatment was not administered as prescribed.	I 474		